# Letters

## Injury from lightning strike while using mobile phone

### Statistics and physics do not suggest a link

Editor—The letter by Esprit et al reporting a case of injury from lightning strike while using a mobile phone required some better research into the physics of lightning, conductors, and statistics.[1]

Firstly, the statistics are few. Three mentions of people using a mobile phone while being hit by a lightning strike is by no means compelling evidence for a correlation for either the strike or unusually serious injury. Indeed, one of the pieces of evidence does not support the theory of a mobile phone causing serious injury: "Last year, 10 tourists seeking shelter [were] struck by lightning when one of them was using a mobile phone. Fortunately, no one was seriously injured."[2] Not enough evidence is presented to argue that use of a mobile phone either attracted the strike or caused serious injury.

Secondly, the suggestion that the metal in a mobile phone is channelling the path of the current through the body is unlikely. The amount of metal in a typical mobile phone is very small, compared to the amount of plastic containing it, with the key being that the outer shell is usually all plastic. A typical mobile phone is better described as an insulator than a conductor.

Thirdly, lightning strikes occur because charges build up in the cloud and the ground until a critical electric field strength is reached. A discharge then occurs. If some of the charge can move higher up from the surface of the earth, drawn by the attraction of the opposite charge in the cloud above, then the strike is more likely to occur. So stabbing a long metal pole into the ground and holding on to it is asking for trouble, but holding a very small amount of metal inside an insulated plastic case is unlikely to enhance the electric field enough to increase the risk of a strike much further.

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Competing interests: None declared.

1 Esprit S, Kothari P, Dhillon R. Injury from lightning strike while using mobile phone. *BMJ* 2006;332:1513. (24 June.)
2 Cell phone could have led to death of tourist on Great Wall. China View 15 August http://news.xinhuanet.com/english/2005-08/15/content_3355652.htm (accessed 30 Jun 2006).

### Mobile phones are not lightning strike risk

Editor—The claim in the letter by Esprit et al, that mobile phones are a risk when used in a storm, is misleading.[1] Although some people speculate that mobile phones pose a risk when used outdoors because lightning is attracted to metal, mobile phone handsets generally contain insignificant amounts of metal.

Following worldwide media interest in the letter, the US National Oceanic and Atmospheric Administration (NOAA) responded, saying lightning is not attracted to people carrying mobile phones: "People are struck because they are in the wrong place at the wrong time. The wrong place is anywhere outside. The wrong time is anytime a thunderstorm is nearby."[2] The medical profession is well aware of the misinformation on this topic as pointed out by Cooper.[3]

The types of injury observed in the letter are also well known[4] and Cooper also points out that no lightning danger is inherent to mobile phones.[5] Although many reports of lightning injuries affect people who are using mobile phones, these reports represent the ubiquity of mobile phone usage and of their users' inattentiveness to weather conditions and have nothing to do with the phones themselves.[5]

Furthermore, the claim that the Australian Lightning Protection Standard recommends mobile phones should not be used during storms is incorrect. The standard (AS/NZS 1768-2003, not AS/170 as cited) does not make any such recommendation. It advises people to use mobile phones instead of conventional corded telephones during storms because conventional phones pose a well documented risk.

The real risk presented by this letter is people may not have their mobile phone with them to call emergency services if someone is struck by lightning nearby.

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1 Esprit S, Kothari P, Dhillon R. Injury from lightning strike while using mobile phone. *BMJ* 2006;332:1513. (24 June.)
2 US National Oceanic and Atmospheric Administration (NOAA). Debunking lightning's connection to cell phones. www.noaanews.noaa.gov/stories2006/s2645.htm (accessed 29 Jun 2006).
3 Cooper MA. *Lightning injury facts myths, miracles, and mirages, adapted from seminars in Neurology 1995;15.* www.uic.edu/labs/lightninginjury/ltnfacts.htm (accessed 28 Jun 2006).
4 Cooper MA. Disability not death is the main problem. *Natl Weather Digest*, 2001;25:43-7. www.uic.edu/labs/lightninginjury/Disability.pdf (accessed 28 Jun 2006).
5 *Lightning Injuries eMedicine Clinical Knowledge Base.* last updated 26 October 2005. www.emedicine.com/emerg/topic299.htm (accessed 28 Jun 2006).

## Hypertrophic cardiomyopathy

### Sudden death is rare in young people with hypertrophic cardiomyopathy

Editor—In their review on the management of hypertrophic cardiomyopathy Spirito and Autore claim that the condition is the most common cause of sudden death in young people without symptoms.[1] This is incorrect. The table summarises the results of 12 studies that provided data on the number of deaths due to hypertrophic cardiomyopathy in young people[2-5] (nine of which were summarised by Liberthson[3]). Less than 10% of all sudden deaths in young people were due to hypertrophic cardiomyopathy. The commonest cause, despite the young age, was coronary artery disease.[3 4]

Most deaths from hypertrophic cardiomyopathy, contrary to perception, occur in older people.[2] In the general young adult population the annual death rate from previously undiagnosed hypertrophic cardiomyopathy is one per million or less (table). Among asymptomatic people known to have the disorder the death rate (case-fatality) is 0.2% per year or less. These results are important with respect to advising patients of their prognosis.

Spirito and Autore recommend screening for the disorder in families of affected cases but provide no quantitative evidence to show that this would be worth while. It would undoubtedly lead to a large number of diagnosed cases, but few would die unexpectedly from the disorder and there is no treatment that could reasonably be offered to all.

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1 Spirito P, Autore C. Management of hypertrophic cardiomyopathy. *BMJ* 2006;332:1251-5. (27 May.)

Sudden deaths from hypertrophic cardiomyopathy (HCM) in young people

| Reference, case population | Age (years) | No of sudden deaths | Annual death rate in general population (per million) | Case fatality rate (per year) | Sudden deaths attributed to HCM (%) |
|---|---|---|---|---|---|
| Wald et al,[2] asymptomatic people with HCM in England and Wales | <55 | 37 | 4 | 0.06 | |
| Liberthson,[3] asymptomatic and symptomatic people with HCM from nine populations in USA, Sweden, Israel, and Italy | <40 | 49 | | | 6* |
| Corrado et al,[4] asymptomatic and symptomatic people with HCM in Veneto, Italy: | | | | | |
| Athletes | ⩽35 | 1 | 0.3 | | 2 |
| Non-athletes | ⩽35 | 16 | 0.5 | | 7 |
| Takagi et al,[5] asymptomatic people with HCM in Tsu, Japan | 20-71 | 1 | | 0.2 | |

*10% of cardiac sudden deaths.


2 Wald DS, Law M, Morris JK. Mortality from hypertrophic cardiomyopathy in England and Wales: clinical and screening implications. *Int J Cardiol* 2004;97:479-84.
3 Liberthson RR. Sudden death from cardiac causes in children and young adults. *N Engl J Med* 1996;334:1039-44.
4 Corrado D, Basso C, Maurizio S, et al. Screening for hypertrophic cardiomyopathy in young athletes. *N Engl J Med* 1998;339:364-9.
5 Takagi E, Yamakado T, Nakano T. Prognosis of completely asymptomatic adult patients with hypertrophic cardiomyopathy. *J Am Coll Cardiol* 1999;33:206-11.


### Combination of β blockers and verapamil may be risky

EDITOR—Spirito and Autore recommend β blockers or verapamil, or the two drugs combined, to control heart rate in patients with hypertrophic cardiomyopathy and chronic atrial fibrillation.[1] To recommend the combination of β blockers and verapamil without more specifications is, in our opinion, too risky.

Both β blockers and verapamil have negative inotropic effects, which can be additive. Given together they can cause marked bradycardia and may depress ventricular contraction,[2] as well as increase the risk of atrioventricular block.[3] Verapamil can also raise the serum concentrations of β blockers that are extensively metabolised in the liver (metoprolol, propranolol), possibly by inhibiting their metabolism.[2] Moreover, as was mentioned in consensus guidelines,[4] there is no evidence that combined medical treatment with β blockers and verapamil is more advantageous that the use of either drug alone.[1] To our knowledge, the situation has not changed.


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1 Spirito P, Autore C. Management of hypertrophic cardiomyopathy. *BMJ* 2006;332:1251-5. (27 May.)
2 Baxter K, ed. *Stockley's drug interactions*. 7th ed. London: Pharmaceutical Press, 2006.
3 López-Sendón J, Swedberg K, McMurray J, Tamargo J, Maggioni AP, Dargie H, et al. Expert consensus document on beta-adrenergic receptor blockers. *Eur Heart J* 2004; 25:1341-62.
4 Maron BJ, McKenna WJ, Danielson GK, Kappemberger LJ, Kuhn HJ, Seidman CE, et al. American College of Cardiology/European Society of Cardiology clinical expert consensus document on hypertrophic cardiomyopathy. *J Am Coll Cardiol* 2003;42:1687-713.


### Authors' reply

EDITOR—Wald and Law assert that coronary artery disease, rather than hypertrophic cardiomyopathy, is the most common cause of sudden and unexpected cardiac death in the young. Our differing conclusions were based on the recent guidelines on hypertrophic cardiomyopathy and on the results of a large and systematic evaluation of the causes of sudden death in competitive athletes.[1] We believe that this discrepancy has two major explanations.

Firstly, the ages of the patient populations discussed are different. We referred to patients in their "youth" (adolescents or young adults) and to athletes. Instead, most of the studies quoted by Wald and Law include adult patients, some aged up to 71.

Secondly, two dimensional echocardiography, the technique that first permitted an immediate identification of the morphological features typical of hypertrophic cardiomyopathy, became available only in the early 1980s. However, the papers from the Liberthson review quoted by Wald and Law were based on epidemiological studies performed from the 1950s to the early 1980s, when the diagnosis of hypertrophic cardiomyopathy remained a major clinical challenge.

Borja et al comment that the combination of β blockers and verapamil may cause bradycardia and could be too risky for patients with hypertrophic cardiomyopathy. They also point out that such treatment strategy is not recommended by the recent guidelines on hypertrophic cardiomyopathy.[1]

In our review, as in others,[2] the use of either β blockers or verapamil, or the combination of both drugs, is suggested exclusively to control the ventricular rate in patients with hypertrophic cardiomyopathy and chronic atrial fibrillation. Conversely, the use of the two drugs combined is not appropriate for the treatment of heart failure. The statement they quote refers to the control of symptoms of heart failure.


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1 Maron BJ, McKenna WJ, Danielson GK, Kappenberger LJ, Kuhn HJ, Seidman CE, et al. American College of Cardiology/European Society of Cardiology clinical expert consensus document on hypertrophic cardiomyopathy. *J Am Coll Cardiol* 2003;42:1687-73.
2 Elliott P, McKenna WJ. Hypertrophic cardiomyopathy. *Lancet* 2004;363: 1881-91.


## American Psychiatric Association clarifies its position on human rights

EDITOR—Justo underscores the key principles on which the American Medical Association and the American Psychiatric Association (APA) have based their position statements on physicians' participation in the integration of detainees.[1] As immediate past president of the APA, I would like to elaborate on the rationale for the APA's position that would preclude psychiatrists from being part of the behavioural science consultation teams.

In the discussion and debate in American psychiatry that led to this position, some psychiatrists felt strongly that consulting with military or domestic law enforcement authorities was justifiable if interrogations were "non-coercive" and adhered to principles of disclosure and respect for persons. Furthermore, these psychiatrists thought it was our "patriotic duty" to participate in interrogations.

This point of view did not prevail. A large majority took the view that interrogations such as those taking place with the help of the behavioural science consultation teams in Guantanamo Bay, Cuba, are inherently coercive. In traditional forensic evaluations psychiatrists and other doctors always seek informed consent from a detainee before the beginning of an evaluation. If the detainee declines no further interaction takes place, but the nature of interrogations does not allow this refusal to participate. Interrogations, however, involve pressure to talk, psychological manipulation, and often induction of stress. This is true even in so called "non-coercive interrogations."

Furthermore, interrogations are often deceptive in which the goal is to pressure or trick a detainee into revealing information that the detainee does not want disclosed. This is a legitimate task for law enforcement or the military, but not for doctors.

Finally, doctors' participation in interrogations will undermine detainees' trust in medical care, once it is known that doctors are part of the interrogation team detainees will justifiably suspect all doctors and their ability to treat detainees' medical needs.

The APA believes that participating in interrogations is inherently coercive and deceptive and undermines the trust in the doctor-patient relationship.

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1 Justo L. Doctors, interrogation, and torture. *BMJ* 2006;332:1462-3. (24 June.)

## Deaths on acute hospital wards

Editor—The story of the dying teenager Andrew, written by his mother, highlights the potential problems encountered by patients and their families at the end of life when cared for in acute hospitals.[1]

Recent government directives have given patients the choice to consider end of life care at home. For some this is wanted and hopefully achievable, but for others, their initial desire to stay at home may change for predictable and unpredictable reasons. Unbearable pain usually strikes in the middle of the night,[1] and, as in Andrew's case, many patients are admitted to hospital at this stage.

The environment of acute busy wards is not always appropriate for the needs of dying patients and their families. Andrew felt safer in the hospital setting, but dying in such a unit is not the best choice, if one has a choice. With constant pressure for the admission of patients who can be treated successfully, to use such a unit for palliative care only is not good use of resources.

The "successful treatment" of an acute medical or surgical problem needs to take place on acute wards. Likewise "successful treatment" of the dying patient with complex needs should take place in a suitable environment with highly skilled staff. Such specialist palliative care units exist in acute trusts for "palliative care only" to provide a seamless service for dying patients in this setting. They are also sometimes able to take patients whose ongoing need for medical support makes transfer to a hospice inappropriate.

NHS run palliative care units on the sites of acute hospitals are undoubtedly a step forward in providing active palliative care of patients. However, because their benefits are not easy to measure, they have been threatened with closure in our region. We are concerned that their extinction will result in suboptimal care of the dying and the problems encountered by families such as Andrew's will increase. Perhaps the government should be listening to carers with first hand experience of relatives dying on acute busy wards when considering such closures?

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1 Darnill S, Gamage B. The patient's journey: palliative care—a parent's view. *BMJ* 2006;332:1494-5. (24 June.)

## Human health resources are key to HIV treatment in Africa

Editor—Deeks singled out drug availability and limited resources in terms of equipment as some of the constraints facing Africa with regard to antiretroviral treatment.[1] Globally, financial resources are not regarded as the main immediate constraint anymore, the lack of human resources for health being regarded as the single most serious obstacle to the roll out of antiretroviral treatment.[2–5]

Not only is the number of health professionals for national health systems in general insufficient but there is even a greater shortage of staff involved in antiretroviral treatment. The few human resources available are maldistributed, most staff residing in urban areas. When this is coupled with unsatisfactory working conditions characterised by overwork, lack of support, burnout, and lack of equipment, people are simply overwhelmed. The production of health professionals by institutions of higher learning is not on the increase as might be expected, and the capping of the number of new entrants through governmental budgetary constraints and the shrinking numbers of academics through retirement without replacement contribute to the decreased throughput.

Clearly the one way major donors could assist in addressing global perspectives relating to antiretroviral treatment and health of populations in developing countries is to commit to human resources development. This assistance could be unveiled by helping countries to develop a coherent human resources strategy, an implementation plan, and providing more funding to enable access to higher education.

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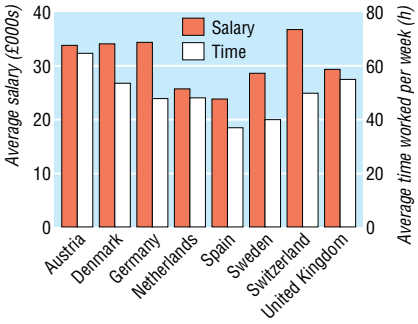
Competing interests: None declared.

1 Deeks SG. Antiretroviral treatment of HIV infected adults. *BMJ* 2006;332:1489-93. (24 June.)
2 Hongoro C, McPake B. Human resources in health: putting the right agenda back to front. *Trop Med Int Health* 2003;8:965-6.
3 Liese B, Blanchet N, Dussault G. *The human resource crisis in health services in Sub-Saharan Africa.* Background paper. Washington, DC: World Bank, 2003.
4 Loewenson R, McCoy D. Access to antiretroviral treatment in Africa. *BMJ* 2004;328:241-2.
5 McCoy D, Chopra M, Loewenson R, et al. Expanding access to antiretroviral therapy in sub-Saharan Africa: avoiding the pitfalls and dangers; capitalizing on opportunities. *Am J Public Health* 2005;95:18-22.

## Does the UK have the highest paid doctors in Europe?

Editor—With the NHS budget deficit spiralling out of control, politicians are looking for scapegoats. One of the largest and easily identifiable costs to the NHS is that of wages. The pay deals negotiated have led to the claim by the health secretary that UK doctors are the highest paid doctors in Europe.[1] We were therefore interested if there were any data to substantiate this claim.




Average salary (£000s) of and number of hours worked per week by doctors in Europe

We decided to look at senior house officers as they constitute 24% of the workforce.[2] We contacted by letter all the medical associations in the BMA booklet *Opportunities for Doctors Within the European Economic Area.* We requested the following information from each country. What is the average salary for a hospital doctor three years after qualification from medical school? What is the average number of hours worked per week? Out of 16 countries contacted, seven responded.

We took UK pay from the BMA website.[3] We converted all values to UK pounds.

UK doctors don't seem to be the highest paid in Europe (figure). Clearly, however, this is a rough estimate on what the pay and working hours of doctors in the UK are compared with doctors in Europe. To compare across nations is near impossible. This is due to the following reasons: the tax system of each country varies; bonuses at the end of each year are given in some countries. Some districts in countries have different conditions of work. House prices, inflation, and pensions should be taken into consideration.

In relation to the European Working Time Directive it seems that many countries are failing to meet the necessary target. We hope this letter shows that the sweeping statement by the health minister that UK doctors are the best paid doctors in Europe is misleading.

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1 www.doctors.net.uk. Hewitt hammers doctors. 14 March 2006.
2 Triggle N. Why are there mounting NHS debts? 6 June 2006. http://news.bbc.co.uk/1/hi/health/4687238.stm (accessed 23 Jun 2006).
3 British Medical Association. Junior Doctors Committee annual report www.bma.org.uk/ap.nsf/content/jdcannualreport2005 (accessed 23 Jun 2006).

## Training doctors in the new English NHS

### Political correctness or evidence based education?

EDITOR—Hutchinson presents a one sided, simplistic, and politically correct view of medical education.[1] Many of her statements were generalisations unsupported by evidence, with the result that her article irritated rather than informed the reader. It focused on a patient led service and changing roles as the challenges to training.

I challenge the assumption that every patient and every situation requires information and choice, otherwise the doctor is not doing things the way he or she should, or that doctors see devolving care to other professionals as a threat. However, I do agree with her question at the end of the article, whether curriculums and assessments truly reflect the type of doctor the public will expect in future years. The answer is no.

Patients expect that after five years at medical school, new doctors would have taken a rigorous examination in medicines and prescribing, know how to recognise and basically manage an emergency, and have been trained in the diagnostic process (clinical reasoning and the interpretation of tests included), for example. Whenever I ask, patients prefer easy access and competence over choice and "niceness" (which is effectively what our medical students are trained in) but everyone wants information. The real challenges are how to produce expert professionals in a shorter time, with poor infrastructure, in a culture that emphasises competency rather than expertise. This article seemed to miss the point.

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1 Hutchinson L. Challenges of training doctors in the new English NHS [with commentaries by AJJA Scherpbier and JJ Gordon]. *BMJ* 2006;332:1502-6. (24 June.)

### Hidden agenda is obvious

EDITOR—This "analysis" from the Office of the Strategic Health Authority is simply an agenda for training NHS apprentices with limited understanding or knowledge of medical sciences.[1] The cat is out of the bag.

The author says that it has always seemed incongruous that the brightest of school leavers, spending five or more years in the most expensive of higher education courses, are still not ready for their job for several years. Incongruous to whom? Not the doctors or the patients. The teaching of medical sciences is expensive and time consuming but essential to combat quackery, superstition, and habit.

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### The real challenge to the medical profession

EDITOR—Hutchinson has done us all a favour.[1] Her article—full of unfounded assumptions and opinion disguised as fact—merely draws attention to the poverty of the arguments of those promoting NHS reforms. Moreover, her case is poorly served by an excess of tiresome jargon. Apparently, if medical training is to assist the "cultural change," we need to "role model patient engagement" and use the "patient voice"; we must check documentation for "subtle messages" and ensure we have "embedded patient autonomy and team working."


The message, though, is clear: if medical students do not think "correctly"—if they do not toe the party line—then they must be taught to do so. Medical education is to be manipulated to achieve a political objective. The author seems to care little for the medical profession, seeing it primarily as an obstacle to progress. She has no qualms about devolving duties formerly the domain of doctors to other healthcare workers and disingenuously implies that such changes are not driven by the need to reduce expenditure. As for medical schools, she finds it "incongruous" that the brightest of school leavers, spending five or more years in the most expensive of higher education courses, are still not "job ready" for several years. Precisely to whom does this seem "incongruous"? If to the layman, then the apparent incongruity may be resolved by giving a detailed account of the knowledge and skills to be acquired before qualification. If to a member of the medical profession, then all that can be said is that a fine education has been wasted on him or her.

The challenge to the medical profession is to argue vociferously against all who peddle reforms that belittle and degrade the practice of medicine.

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## Does continuing medical education work?

EDITOR—There seems to be some inborn belief among editors and educators that continuing medical education (CME) works.[1] What is the evidence? The few attempts to measure effectiveness have been less than satisfactory. Recall may be fine immediately after a lecture, but how is it three to six months later? How do we measure changes in practice? What causes those changes? How much CME is based on studies of individual practices? CME is not based on practice epidemiology. How much CME and practice content is based on assessments of the problems in a specific practice population? One of my first published papers was written in 1958 on my experience of placing my patients' data on Royal McBee punch cards and evaluating the content of my practice (diagnoses, procedures, prescriptions) every six months.

One CME size does not fit all, any more than one design fits all. People learn in different ways. Some do well searching for ideas on the internet. Some find journal articles worthwhile. Some find repetition of subjects boring.

The desire to ensure the best quality practice is laudable. With proper training in medical school most doctors subscribe to life long learning, yet we still see such simple activities as lack of immunisation among patients in a practice. Many patients do not have their blood pressure measured regularly. We often measure the wrong things. We provide the wrong type of continuing education. We pay for services based on quantity rather than quality. We do not pay for consultations but for surgery, shots, and prescriptions.

Those truly interested in improving physician performance need to dump CME as it presently exists and develop a new model to improve practice quality, once we have decided what quality is. It is not usually what professors and educators believe it is. The worry about pharmaceutical support is a distraction from focusing on practice quality.

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1 Godlee F. What price integrity? [Editor's choice.] *BMJ* 2006;332:0. (17 June.)

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